

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Environmental

Asthma <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent	<input type="checkbox"/> Other : _____

Seizures <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type: _____	Date of last seizure: _____

Diabetes <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____	Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:

Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI _____ kg/m2 **Percentile (Weight Status Category):** <5th 5th-49th 50th-84th 85th-94th 95th-98th 99th and >

Hyperlipidemia: No Yes Hypertension: No Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 10 \mu\text{g/dL}$				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name:			DOB:	
SCREENINGS				
Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis Required for boys grade 9 And girls grades 5 & 7	Negative	Positive	Referral	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
<input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics. <input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications <input type="checkbox"/> No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling <input type="checkbox"/> No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field <input type="checkbox"/> Other Restrictions:				
<input type="checkbox"/> Developmental Stage for Athletic Placement Process ONLY Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports Student is at Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> Accommodations: Use additional space below to explain <input type="checkbox"/> Brace*/Orthotic <input type="checkbox"/> Colostomy Appliance* <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Insulin Pump/Insulin Sensor* <input type="checkbox"/> Medical/Prosthetic Device* <input type="checkbox"/> Pacemaker/Defibrillator* <input type="checkbox"/> Protective Equipment <input type="checkbox"/> Sport Safety Goggles <input type="checkbox"/> Other: *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
MEDICATIONS				
<input type="checkbox"/> Order Form for Medication(s) Needed at School attached				
List medications taken at home:				
IMMUNIZATIONS				
<input type="checkbox"/> Record Attached	<input type="checkbox"/> Reported in NYSIIS	Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No		
HEALTH CARE PROVIDER				
Medical Provider Signature:			Date: _____	
Provider Name: <i>(please print)</i>			Stamp:	
Provider Address:				
Phone:				
Fax:				
Please Return This Form To Your Child's School When Entirely Completed.				

Berlin Central School District

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: New to the district, Pre-K or K, 1, 3, 5, 7, 9 & 11. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Sex: Male Will this be your child's first visit to a dentist? Yes No
Month Day Year
 Female

School: Name Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? Yes No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

- Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.
 No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp) Dentist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here.

II. Oral Health Status (check all that apply).

- Yes No **Caries Experience/Restoration History** - Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].
 Yes No **Untreated Caries** - Does this child have an open cavity? [At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].
 Yes No **Dental Sealants Present**

Other problems (Specify): _____

III. Treatment Needs (check all that apply)

- No obvious problem. Routine dental care is recommended. Visit your dentist regularly.
 May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.
 Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

**BERLIN CENTRAL SCHOOL
MEDICATION CONSENT FORM**

To be completed and signed by student's Licensed Health Care Provider
(New York State law requires that all medication orders for students be patient specific)

Section I: Indicate approval/disapproval of the following over the counter medications & treatments for use at school. **The school will stock these medications if approved.**

Medication Name	Dosage & Indication For Use	Physician Approval	Physician Disapproval	Concerns/Comments
Acetaminophen (Tylenol)	Per label instructions Per age/wt.	Yes ____	No ____	
Ibuprofen (Motrin)	Per label instructions Per age/wt.	Yes ____	No ____	
Bacitracin (Antibiotic) Ointment	Per Label Instructions	Yes ____	No ____	
Burn Ointment	Per Label Instructions	Yes ____	No ____	
Caladryl (Anti-itch) Lotion	Per Label Instructions	Yes ____	No ____	
Benzalkonium (Antiseptic) Solution	Per Label Instructions	Yes ____	No ____	
Medicaine (Insect Bite) Swabs	Per Label Instructions	Yes ____	No ____	
Orajel (Toothache)	Per Label Instructions	Yes ____	No ____	
Sunscreen/Sunburn	Per Label Instructions	Yes ____	No ____	
Benadryl (Diphenhydramine HCL)	Per Label Instructions	Yes ____	No ____	
Cough Drops	Per Label Instructions	Yes ____	No ____	
Dramamine (Motion Sickness)	Per label instructions Per age/wt.	Yes ____	No ____	Overnight Field Trip Use Only
Peptobismol (Stomach Relief)	Per label instructions Per age/wt.	Yes ____	No ____	Overnight Field Trip Use Only

Section II: Please list student's use of prescription and/or non-prescription medications and indicate the need for use at school. **Parents are responsible for providing these medications.**

Medication	Route	Dosage	Frequency/Indications	Comments	Use at School
					Yes/No
					Yes/No
					Yes/No

Section III: Please indicate if the student is self-directed and may carry their medication.

Yes (Student **is** self-directed) No (student **is not** self-directed)

Section IV: Please provide the appropriate signatures and return to Health Office.

Licensed Provider's Name: _____ Phone Number: _____

Licensed Provider's Signature: _____ Date: _____

Student's Name: _____ Parent Signature: _____ Date: _____